Wisconsin Medicaid
Specialized Medical Vehicle (SMV)
Certification Packet

Wisconsin
Department of
Health and Family Services

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

Dear Medicaid Provider Applicant:

Thank you for applying for certification with the Wisconsin Medicaid program. Once you are a Medicaid provider, you will play a significant part in improving the health of low-income people in your community.

Enclosed are the certification materials you requested. Please review these materials carefully. These materials must be completed and processed before you may become a certified provider for the Wisconsin Medicaid program and begin receiving payments.

Upon certification as a Wisconsin Medicaid provider, you will receive the All Provider Handbook containing general instructions for all providers. In addition, you will also receive publications relating to the specific services you will be providing. These publications will identify the services covered by the Medicaid program and will describe Medicaid billing procedures. After reading those materials, if you have additional questions, we encourage you to use provider services. These services include both telephone and on-site assistance. If you are interested in using these services, please contact the Provider Services Unit addresses and telephone numbers listed in the All Provider Handbook.

We realize that all providers appreciate prompt payments, so we encourage providers with computers to submit claims electronically. This method reduces clerical errors and decreases turn around time. If you are interested in electronic submission of claims and would like more information, including the free software, please contact (608) 221-4746. Information is included in your certification materials regarding electronic submission of claims.

Thank you, again, for your interest in becoming a certified Wisconsin Medicaid provider and for the important services that you will provide to Medicaid recipients. If you have any questions about enclosed materials, please contact the Wisconsin Medicaid Correspondence Unit at (608) 221-9883 or toll-free at 1-800-947-9627.

Sincerely,

Peggy B. Handrich

Peggy B. Handrich
Associate Administrator

PBH:mhy
MA11065.KZ/PERM

Enclosure

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Dear SMV Provider:

Thank you for choosing to serve the disabled Medicaid population of Wisconsin. It is the responsibility of the Wisconsin Medicaid Program to assure that quality and timely Medicaid-covered services are provided to the recipients of Medicaid by appropriately certifying Medicaid provider applicants.

As an applicant to provide specialized medical vehicle (SMV) non-emergency transportation you are agreeing to serve a limited population of disabled recipients that cannot safely access any means of transportation other than a vehicle equipped with a ramp or lift, or an ambulance. When Medicaid receives a complete provider certification application, the Bureau of Health Care Program Integrity (BHCPI) will review the application and you will receive a provider number. The BHCPI will also schedule an on-site visit with you to review your application materials and your operation to ensure the necessary resources are in place to provide services to Medicaid recipients. The review will be conducted at the business address provided in the application. The on-site review announcement will be sent by certified mail. Failure to sign for and accept official correspondence could result in a delay in processing the application and your certification, and could possibly result in decertification.

The review will include, but not be limited to, evaluating the application packet information, an interview of the company owner and/or manager and a review of insurance, resources and any other required documents. The BHCPI will also briefly view the vehicles documented on the SMV Information Chart and check any additional documentation on the drivers documented on the SMV Driver Information Chart.

Again, thank you for your interest and application. If you have questions as to the status of your application, please contact Provider Services at 1-800-947-9627.

Sincerely,

Alan S. White, Director
Bureau of Health Care Program Integrity

ASW:my
PR06049.CW

Wisconsin Medicaid
Checklist for Certification

The items listed below are included in your certification application. Please use this form to check that you received the materials and verify which materials you returned. Please copy all documents for your records before sending them to the fiscal agent. Keep this checklist for your records. Mail your completed application to:

Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

The required items must be completed and returned to EDS:

	Item	Required	Optional	Date Sent
1.	Provider Application	X		
2.	Attachment A (Part 2) for SMV Providers (carefully read all pages):			
	a) Vehicle Chart - Complete and return with the Department of Transportation (DOT) approval forms and detailed insurance documentation for each Vehicle Identification Number listed on the chart(s)	X		
	b) Driver Chart - Complete and return with a copy of current First Aid and Cardiopulmonary Resuscitation Cards for each driver	X		
	c) SMV Affidavit - Complete page 1 and have it notarized on page 4	X		
	d) If applicable, Certificate of Worker's Compensation Insurance		X	
3.	Provider Agreement (2 copies)	X		

These items are included for your information. Do not return them:

	Item
1.	General Information
2.	Attachment A (Part 1)
3.	Terms of Reimbursement
4.	Weekly Driver's Vehicle Inspection Report Form
5.	Example DOT Form
6.	Wisconsin Division of State Patrol District Map
7.	Example SMV Trip Ticket

Wisconsin Medicaid Program
General Certification Information

Enclosed is the certification application you requested to be a Wisconsin Medicaid provider. Your certification for Wisconsin Medicaid can be approved when you send a **correctly completed application** to the address below and meet all certification requirements for your provider type. **Wisconsin Medicaid cannot reimburse any services you provide prior to your approved certification effective date.** Please carefully read the attached materials.

Where to Reach Us

If you have questions about the certification process, please call the Wisconsin Medicaid Correspondence Unit for Policy/Billing Information at (608) 221-9883 or toll-free at 1-800-947-9627.

Copy all application documents for your records. Send your completed certification materials to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Certification Effective Date

Wisconsin Medicaid regulations are followed when assigning your initial effective date as described here:

1. The date you notify Wisconsin Medicaid of your intent to provide services is the earliest effective date possible and will be your initial effective date **if**:
   - You meet all applicable licensure, certification, authorization, or other credential requirements as a prerequisite for Medicaid on the date of notification. Do not hold your application for pending licensure, Medicare, or other required certification. Wisconsin Medicaid will keep your original application on file. Send Wisconsin Medicaid proof of eligibility documents immediately once available for continued processing.
   - Wisconsin Medicaid receives your **properly completed certification** application within 30 days of the date the application was mailed to you.

2. If Wisconsin Medicaid receives your application more than 30 days after it was mailed to you, your initial effective date will be the date Wisconsin Medicaid receives your correctly completed application.

3. If Wisconsin Medicaid receives your incomplete or unclear application within the 30-day deadline, you will be granted one 30-day extension. Wisconsin Medicaid must receive your response to Wisconsin Medicaid's request for additional information within 30 days from the date on the letter requesting the missing information or item(s). This extension may allow you additional time to obtain proof of eligibility (such as license verifications, transcripts, other certification, etc.)

4. If you don't send complete information within the original 30-day deadline or 30-day extension, your initial effective date will be based on the date Wisconsin Medicaid receives your complete and accurate application materials.

Notification of Certification Decision

Within 60 days after Wisconsin Medicaid receives your completed application, you will be notified of the status of your certification. If Wisconsin Medicaid needs to verify your licensure or credentials, it may take longer. You will be notified as soon as Wisconsin Medicaid completes the verification process.

If you are certified to provide Medicaid services, you will receive written notice of your approval, including your Wisconsin Medicaid provider number and certification effective date.

Notification of Changes

Your certification in Wisconsin Medicaid is maintained only if your certification information on file at Wisconsin Medicaid is current. You must inform Wisconsin Medicaid in advance of any changes such as licensure, certification, group affiliation, corporate name, ownership, and physical or payee address. **Send your written notice to Wisconsin Medicaid Provider Maintenance**. This notice must state when these changes take effect. Include your provider number(s) and signature. Do not write your notice or change on claims or prior authorization requests.

Failure to notify Wisconsin Medicaid of these types of changes may result in:

- Incorrect reimbursement.
- Misdirected payment.
- Claim denial.
- Suspension of payments in the event provider mail is returned to Wisconsin Medicaid for lack of current address.

Provider Agreement Form

Your agreement to provide Medicaid services must be signed by you and the Wisconsin Department of Health and Family Services. This agreement states that both parties agree to abide by Wisconsin Medicaid's rules and regulations.

The agreement is valid for a maximum of one year. All Provider Agreements expire annually on March 31. The Department of Health and Family Services may renew or extend the Provider Agreement at that time.

You cannot transfer, assign, or change the Provider Agreement.

The application includes two copies of the Provider Agreement. Complete, sign, and return both copies. Type or clearly print your name as the applicant's name both on the line on page 1 and on the appropriate line on the last page of the agreement. You must use the same provider name on the application forms and Provider Agreement. When the certification process is complete, you will receive one copy of your processed and signed Provider Agreement. The other copy will be kept in your Wisconsin Medicaid file.

Terms of Reimbursement (TOR)

The TOR explains current reimbursement methodologies applicable to your particular provider type. It is referenced by, and incorporated within, the provider agreement. Keep the TOR for your files.

Certification Requirements

The Wisconsin Administrative Code contains requirements that providers must meet in order to be certified for Wisconsin Medicaid. The code and any special certification materials applicable to your provider type are included as certification requirements.

Publications

Along with your notice, Wisconsin Medicaid will send one copy of all applicable provider publications. The publications include program policies, procedures, and resources you can contact if you have questions.

Many clinics and groups have requested to receive only a few copies of each publication, rather than a personal copy for each Medicaid-certified individual provider in the clinic or group. If you are an individual provider who is a member of a Medicaid-certified clinic or group, you may reassign your copy to your clinic or group office. Please decide if you wish to receive your personal copy of Medicaid publications or if it is sufficient for your Medicaid-certified clinic or group office to receive copies.

If you do not wish to receive personal copies of Medicaid publications, please complete the attached "Deletion from Publications Mailing List Form." If you wish to have your copy of publications reassigned to your clinic or group, also complete the "Additional Publications Request Form."

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SPECIALIZED MEDICAL VEHICLE TERMS OF REIMBURSEMENT

The Department will establish maximum allowable fees for all covered services provided by certified specialized medical vehicle providers to Wisconsin Medicaid recipients eligible on the date of service. The maximum allowable fees shall be based on various factors, including a review of usual and customary charges submitted to the Wisconsin Medicaid Program, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

Providers are required to bill their usual and customary charges for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to non-Medicaid patients. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum allowable fee established by the Department. Wisconsin Medicaid reimbursement, less appropriate copayments and payments by other insurers, will be considered to be payment in full.

The Department will adjust payments made to providers to reflect the amounts of any allowable copayments which the providers are required to collect pursuant to Chapter 49, Wisconsin Statutes.

Payments for deductible and coinsurance payable on an assigned Medicare claim shall be made in accordance with Section 49.46(2)(c), Wisconsin Statutes.

In accordance with Federal regulations contained in 42 CFR 447.205, the Department will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting maximum allowable fees for services.

Applicable Provider Type(s): 42
Applicable Specialty: 095, 143 (If FQHC)

Effective Date: June 1, 1998

PR08178.KW/TOR (5/98)

WISCONSIN MEDICAID

PROVIDER APPLICATION INFORMATION AND INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary. However, in order to be certified, you must complete this form and submit it to the address indicated.

INSTRUCTIONS: Type or print your information on this application. Complete all sections. If a question does not apply to your application, write "N/A" in the field. Failure to complete all sections of this application will cause delay and may cause denial of certification.

IMPORTANT NOTICE: In receiving this application from and granting Medicaid certification to the individual or other entity named below as "Provider Applicant," Wisconsin Medicaid relies on the truth of all the following statements:

1. Provider Applicant submitted this application or authorized or otherwise caused it to be submitted.
2. All information entered on this application is accurate and complete, and that if any of that information changes after this application is submitted Provider Applicant will timely notify Wisconsin Medicaid of any such change.
3. By submitting this application or causing or authorizing it to be submitted, Provider Applicant agrees to abide by all statutes, rules, and policies governing Wisconsin Medicaid.
4. Provider Applicant knows and understands the certification requirements included in the application materials for the applicable provider types.

If any of the foregoing statements are not true, Wisconsin Medicaid may terminate Provider Applicant's certification or take other action authorized under ch. HFS106, Wis. Admin. Code, or other legal authority governing Wisconsin Medicaid.

DISTRIBUTION — Submit completed form to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Road
Madison WI 53784-0006

If you have any questions, call Provider Services at (800) 947-9627.

FOR OFFICE USE ONLY

ECN	Date Requested	Date Mailed

Provider Number	Effective Date
Provider Type	**Provider Specialty**

WISCONSIN MEDICAID
PROVIDER APPLICATION

INSTRUCTIONS: Type or print clearly. Before completing this application, read Information and Instructions.

This application is for:

☐ Individual.
☐ Group/Clinic.
☐ Change of Ownership, effective __ __/__ __ /__ __ __ __.

SECTION I — PROVIDER NAME AND PHYSICAL ADDRESS

Special Instructions
Name — Provider Applicant — Enter only one name. All applicants (e.g., individuals, groups, agencies, companies) must enter their name on this line. If your agency uses a "doing business as" (DBA), then enter your DBA name. The name entered on this line must exactly match the provider name used on all other documents for Wisconsin Medicaid.

Name — Group or Contact Person — Individual applicants employed by a group or agency should indicate their employer on this line. Applicants who are not employed by a group or agency may use this line as an additional name line or attention line to ensure proper mail delivery.

Address — Physical Work — Indicate address where services are primarily provided. Wisconsin Medicaid will send general information and correspondence to this address. Official correspondence will be sent certified. Failure to sign for official correspondence could result in decertification. It is not acceptable to use a drop box or post office box alone. Do not use a Medicaid recipient's residence or a billing service address.

Date of Birth — Individual / Social Security Number — Required for individual applicants only. Enter date as MM/DD/YYYY.

Name — Medicaid Contact Person, Telephone Numbers, and Fax Number — List the name, telephone number, and fax number of a person within your organization who can be contacted about Medicaid questions. Also list a telephone number clients can use to reach you. This telephone number must be kept current with Wisconsin Medicaid.

Medicare Part A Number and Medicare Part B Number — Required for Medicare-certified providers. Please use Medicare numbers appropriate for the same type of services as this application.

Name — Provider Applicant (Agency Name or Last, First Name, Middle Initial)			
Name — Group or Contact Person			
Address — Physical Work			
City	State	Zip Code	County
Date of Birth — Individual	SSN		Name — Medicaid Contact Person
Telephone Number — Medicaid Contact Person	Telephone Number — For Client Use		Fax Number
Current and/or Previous State Medicaid Provider Number ☐ Wisconsin ☐ Other			
Medicare Part A Number			Effective Date
Medicare Part B Number			Effective Date

SECTION II — ADDITIONAL INFORMATION

Special Instructions
Respond to all applicable items:

- **All applicants must complete question 1. Providers with a physical address in Minnesota, Michigan, Iowa, or Illinois** must attach a copy of their current license.
- **Physicians** must answer **question 2**.
- **Applicants who will bill for laboratory tests** must answer **question 3**. Attach a copy of their current Clinical Laboratory Improvement Amendment (CLIA) certificate.
- **All applicants certified to prescribe drugs** must answer **question 4**.
- **Individuals affiliated with a Medicaid-certified group** must answer **question 5**.

1. Individual or Agency License, Certification, or Regulation Number(s)

2. Unique Physician Identification Number (UPIN)

3. CLIA Number

4. Drug Enforcement Administration (DEA) Number

5. Medicaid Clinic/Group Number

SECTION III — PROVIDER PAYEE NAME AND PAYEE ADDRESS

Special Instructions
Name — Payee — Enter the name to whom checks are payable. Individuals reporting income to the Internal Revenue Service (IRS) under a SSN must enter the individual name recorded with the IRS for the SSN. Applicants reporting income to the IRS under an employer identification number (EIN) must enter the name exactly as it is recorded with the IRS for the EIN.

TIN — Enter the Taxpayer Identification Number (TIN) that should be used to report income to the IRS. Check whether the TIN is an EIN or SSN. The number entered must be the TIN of the payee name entered. The payee name and TIN must exactly match what is on record with the IRS.

TIN Effective Date — This is the date the TIN became effective for the provider.

Name — Group or Contact Person (Optional) — Enter an additional name (e.g., business, group, agency) that should be printed on checks and Remittance and Status (R/S) Reports (payment/denial report) to ensure proper delivery.

Address — Payee — Indicate where checks and R/S Reports should be mailed. A post office box alone may be used for this address.

Name — Payee

TIN	TIN Effective Date	☐ EIN or ☐ SSN

Name — Group or Contact Person

Address — Payee

City	County	State	Zip Code

SECTION IV — TYPE OF CERTIFICATION

Check the provider type for this application from the list below. A separate application is required (in most cases) for each provider type for which you wish to be certified. An individual may choose only one provider type per application.

- ☐ Ambulance.
- ☐ Ambulatory Surgery Center.
- ☐ Anesthesiology Assistant*.
- ☐ Anesthetist CRNA.
- ☐ Audiologist.
- ☐ Audiologist/Hearing Instrument Specialist.
- ☐ Case Management.
- ☐ Chiropractor.
- ☐ Community Care Organization.
- ☐ Dentist, Specialty _____.
- ☐ End Stage Renal Disease.
- ☐ Family Planning Clinic.
- ☐ HealthCheck Screener.
- ☐ HealthCheck "Other" Services:
  - ☐ Other Eligible Services.
- ☐ Hearing Instrument Specialist.
- ☐ Home Health Agency:
  - ☐ With Personal Care.
  - ☐ With Respiratory Care.
- ☐ Hospice.
- ☐ Independent Lab.
- ☐ Individual Medical Supply:
  - ☐ Orthodontist and/or: Prosthetist.
    Other _____.
- ☐ Medical Vendor/Durable Medical Equipment (DME).
- ☐ Nurse Practitioner:
  - ☐ Certified Nurse Midwife (masters level or equivalent).
- ☐ Nurse Services (Independent Home Care):
  - ☐ Respiratory Care Services.
  - ☐ Private Duty.
  - ☐ Midwife.
- ☐ Occupational Therapy (OT).
- ☐ OT Assistant*.
- ☐ Optician.
- ☐ Optometrist.
- ☐ Osteopath (See below).
- ☐ Osteopath Group/Clinic (See below).
- ☐ Personal Care Agency.
- ☐ Pharmacy.
- ☐ Physical Therapy (PT).
- ☐ PT Assistant*.
- ☐ Physician (See below).
- ☐ Physician Assistant*.
- ☐ Physician Group/Clinic (See below).
- ☐ Podiatrist.
- ☐ Portable X-ray.
- ☐ Prenatal Care Coordination (PNCC).
- ☐ Rehabilitation Agency.
- ☐ Respiratory Therapist.
- ☐ Rural Health Clinic.
- ☐ School-Based Services.
- ☐ Specialized Medical Vehicle Transportation.
- ☐ Speech and Hearing Clinic.
- ☐ Speech and Pathology:
  - ☐ Master's Level.
  - ☐ Bachelor's Level*.
- ☐ Therapy Group (Two therapies, i.e., OT and PT).
- ☐ Others (Describe): _____
  _____.

*Individuals must be supervised and cannot independently bill Wisconsin Medicaid. In most cases, the clinic must submit claims.

Osteopaths or physicians, or a group/clinic of an osteopath or physician, must indicate the specialty below (select one specialty):

- ☐ Allergy.
- ☐ Anesthesiology.
- ☐ Cardiovascular Disease.
- ☐ Clinic.
- ☐ Dermatology.
- ☐ Ear, Nose, Throat Otorhinolaryngology.
- ☐ Emergency Medicine.
- ☐ Family Practice.
- ☐ Gastroenterology.
- ☐ General Practice.
- ☐ General Surgery.
- ☐ Geriatrics.
- ☐ Internal Medicine.
- ☐ Manipulative Therapy.
- ☐ Miscellaneous.
- ☐ Nephrology.
- ☐ Neurological Surgery.
- ☐ Neurology.
- ☐ Nuclear Medicine.
- ☐ Obstetrics and Gynecology.
- ☐ Oncology and Hematology.
- ☐ Ophthalmology.
- ☐ Optometry.
- ☐ Orthopedic Surgery.
- ☐ Pathology.
- ☐ Pediatrics.
- ☐ Pediatric Allergy.
- ☐ Pediatric Cardiology.
- ☐ Physical Medicine and Rehab.
- ☐ Plastic Surgery.
- ☐ Preventive Medicine.
- ☐ Proctology.
- ☐ Psychiatry (MDs attach a proof of completed psychiatric residency).
- ☐ Pulmonary Disease.
- ☐ Radiation Therapy.
- ☐ Radiology.
- ☐ Thoracic and Cardiovascular Surgery.
- ☐ Urgent Care.
- ☐ Urology.

SECTION V — MEMBERS OF GROUP OR CLINIC

Required: If this application is for a group or clinic, complete the chart below by listing all individuals providing Medicaid services at the clinic.

Name — Provider	Address — Provider Physical Work	Specialty	License Number	Provider Number

SECTION VI — APPLICANT'S TYPES OF SERVICE PROVIDED AND TYPE OF BUSINESS

1. List the types of Medicaid services the applicant's agency will provide (such as dental, emergency transportation, home health, personal care, pharmacy, physician, psychiatric counseling, respiratory care services, etc.).

2. Applicant's type of business (check appropriate box):

- ☐ Individual.
- ☐ Sole Proprietor:
  County and state where registered _____.
- ☐ Corporation for Nonprofit.
- ☐ Limited Liability.
- ☐ Corporation for Profit.
  State of registration _____

  Names of corporate officers _____

  _____
- ☐ Partnership.
  State of registration _____.

  Names of all partners and SSNs (use additional sheet if needed):

  Name _____ SSN _____

  Name _____ SSN _____

Governmental (check one):

- ☐ County.
- ☐ State.
- ☐ Municipality (city, town, village).
- ☐ Tribal.

- ☐ Other, specify _____.

Definitions for Sections VII-IX

Controlling interest — Controlling interest includes, but is not limited to, those enumerated; that is, all owners, creditors, controlling officers, administrators, mortgage holders, employees or stockholders with holdings of 10% or greater of outstanding stock, or holders of any other such position or relationship who may have a bearing on the operation or administration of a medical services-related business.

SECTION VII — TERMINATION / CONVICTION / SANCTION INFORMATION

Has the applicant, any employee of the applicant, any person in whom the applicant has a controlling interest, or any person having a controlling interest in the applicant been terminated from or convicted of a crime related to a federal or state program?

☐ **Yes** ☐ **No**

If yes, please explain:

SECTION VIII — CONTROLLING INTEREST IN OTHER HEALTH CARE PROVIDERS

Copy this page and complete as needed.

Does the applicant have a controlling interest in any vendors of special service categories such as, but not limited to, drugs/pharmacy, medical supplies/durable medical equipment, transportation, visiting nurse and/or home health agency, providers of any type of therapy?

☐ **Yes.** Identify each health care provider the applicant has a controlling interest or ownership in, supply the information, and describe the type and percentage of controlling interest or ownership (e.g., 5% owner, 50% partner, administrator).
☐ **No.** Go to Section IX.

Name			
Medical Provider Number(s)	SSN/EIN		
Address			
City	State	Zip Code	County
Telephone Number — Business	Telephone Number — Home	Type and percentage of controlling interest or ownership	

Are all of the services provided by the applicant and any special service vendors in which the applicant has a controlling interest billed under a single provider number?

☐ **Yes.** Enter the number:_____.
☐ **No.**

SECTION IX — CONTROLLING INTEREST OTHERS (INDIVIDUAL AND / OR ENTITY) HAVE IN THE APPLICANT

Copy this page and complete as needed.

Does any person and/or entity have a controlling interest in any of the Medicaid services the applicant provides? ☐ **Yes** ☐ **No**

If yes, list the names and addresses of all persons and/or entities with a controlling interest in the applicant.

Name — Individual or Entity			
Address			
City	State	Zip Code	County
Telephone Number — Business	Telephone Number — Home	Type and percentage of controlling interest or ownership	
SSN or IRS Tax Number	Provider Number, if applicable		

ATTACHMENT A

PART 1

SPECIALIZED MEDICAL VEHICLE (SMV) MEDICAID CERTIFICATION CRITERIA

Section HFS 101.03(166) of the Wisconsin Administrative Code defines an SMV as a non-emergency vehicle used to transport a recipient who is confined to a wheelchair or whose condition contraindicates transportation by common carrier, and whose physician has prescribed specialized medical vehicle transportation to a facility at which the recipient primarily receives medical services.

Per section HFS 105.39, Wisconsin Administrative Code:

(1) For MA certification, a specialized medical vehicle provider shall meet the requirements of this section and shall sign the affidavit required under sub. (6) stipulating that the provider is in compliance with the requirements of this section as well as with the requirements of the department of transportation for human service vehicles under ss. 110.05 and 340.01(23)(g), Stats., and ch. Trans. 301, and shall provide proof of compliance when requested by the department.

(2) VEHICLES. (a) Insurance of not less than $250,000 personal liability for each person, not less than $500,000 personal liability for each occurrence and not less than $10,000 property damage shall be carried on each specialized medical vehicle used to transport a recipient.

(b) Each vehicle shall be inspected and the inspection documented at least every 7 days, by an assigned driver or mechanic, to ensure:

1. The proper functioning of the vehicle systems including but not limited to all headlights, emergency flasher lights, turn signal lights, tail lights, brake lights, clearance lights, internal lights, windshield wipers, brakes, front suspension and steering mechanisms, shock absorbers, heater and defroster systems, structural integrity of passenger compartment, air conditioning system, wheelchair locking systems, doors, lifts and ramps, moveable windows and passenger and driver restraint systems;

2. That all brakes, front suspension and steering mechanisms and shock absorbers are functioning correctly;

3. That all tires are properly inflated according to vehicle or tire manufacturers' recommendations and that all tires possess a minimum of 1/8-inch of tread at the point of greatest wear; and

4. That windshields and mirrors are free from cracks or breaks.

(c) The driver inspecting the vehicle shall document all vehicle inspections in writing, noting any deficiencies.

(d) All deficiencies shall be corrected before any recipient is transported in the vehicle. Corrections shall be documented by the driver. Documentation shall be retained for not less than 12 months, except as authorized in writing by the department.

(e) Windows, windshield and mirrors shall be maintained in a clean condition with no obstruction to vision.

(f) Smoking is not permitted in the vehicle.

(g) Police, sheriff's department and ambulance emergency telephone numbers shall be posted on the dash of the vehicle in an easily readable manner. If the vehicle is not equipped with a working two-way radio, sufficient money in suitable denominations shall be carried to enable not less than 3 local telephone calls to be made from a pay telephone. **[NOTE:** Ch. Trans 301.14, requires every HSV to be equipped with some type of 2-way communication system.

The system shall be of such design and installation that the vehicle operator shall at all times be able to communicate with either the base of operations or another intermediary party that could communicate with the base of operations.

(h) A provider shall maintain a list showing for each vehicle its registration number, identification number, license number, manufacturer, model, year, passenger capacity, insurance policy number, insurer, types of restraint systems for wheelchairs and whether it is fitted with a wheelchair lift or with a ramp. Attached to the list shall be evidence of compliance with ch. Trans. 301.

(3) VEHICLE EQUIPMENT. (a) The vehicle shall be equipped at all times with a flashlight in working condition, a first aid kit and a fire extinguisher. The fire extinguisher shall be periodically serviced as recommended by the local fire department.

(b) The vehicle shall be equipped with a lift or ramp for loading wheelchairs. The vehicle shall also be equipped with passenger restraint devices for each passenger, including restraint devices for recipients in wheelchairs or on cots or stretchers as defined in s. HFS 107.23(1)(c)4. Both a recipient and the recipient's wheelchair, cot or stretcher shall be secured.

(c) Provision shall be made for secure storage of removable equipment and passenger property in order to prevent projectile injuries to passengers and the driver in the event of an accident.

(4) DRIVERS. (a) Each driver shall possess a valid regular or commercial operator's license which shall be unrestricted, except that the vision restrictions may be waived if the driver's vision is corrected to an acuity of 20/30 or better by the use of corrective lenses. In this event, the driver shall wear corrective lenses while transporting recipients.

(b) 1. Each driver before driving a vehicle or serving as an attendant shall have received all of the following:

a. Basic Red Cross or equivalent training in first aid and cardiopulmonary resuscitation (CPR);
b. Specific instructions on care of passengers in seizure; and
c. Specific instructions in the use of all ramps, lift equipment and restraint devices used by the provider.

2. A driver who was employed before the effective date of this section [December 1, 1994] and who attests in writing that he or she has had prior training in the topics under subd. 1 shall be considered to have fulfilled the requirements under subd. 1.

3. Each driver shall receive refresher training in first aid every 3 years and maintain CPR certification. A driver who is an emergency medical technician licensed under ch. HFS 110, 111 or 112, a licensed practical nurse, a registered nurse or a physician assistant shall be considered to have met this requirement by completion of continuing education which includes first aid and CPR.

(c) The provider shall maintain a current list of all drivers showing the name, license number and any driving violations or license restrictions of each and shall keep that list current.

(5) COMPANY POLICY. Company policies and procedures shall include:

(a) Compliance with state and local laws governing the conduct of businesses, including ch. Trans. 301;
(b) Establishment and implementation of scheduling policies that assure timely pick-up and delivery of passengers going to and returning from medical appointments;
(c) Documentation that transportation services for which MA reimbursement is sought are:

1. For medical purposes only;
2. Ordered by the attending provider of medical service; and

3. Provided only to persons who require this transportation because they lack other means of transport, and who are also physically or mentally incapable of using public transportation;

(d) Maintenance of records of services for 5 years, unless otherwise authorized in writing by the department; and

(e) On request of the department, making available for inspection records that document both medical service providers' orders for services and the actual provision of services.

(6) AFFIDAVIT. The provider shall submit to the department a notarized affidavit attesting that the provider meets the requirements listed in this section. The affidavit shall be on a form developed by and available from the department, and shall contain the following:

(a) A statement of the requirements listed in this section;

(b) The date the form is completed by the provider;

(c) The provider's business name, address, telephone number and type of ownership;

(d) The name and signature of the provider or a person authorized to act on behalf of the provider; and

(e) A "notarization."

(7) DENIAL OF RECERTIFICATION. If a provider violates provisions of this chapter, s. HFS 106.06, s. HFS 107.23 or any other instruction in MA program manuals, handbooks, updates or letters on provision of SMV services 3 times in a 36-month period, the department may deny that provider's request for recertification.

CHECK FOR ANY LOCAL REQUIREMENTS

Some counties/municipalities in Wisconsin have requirements which SMV providers must meet. No information on Medicaid certification or provision of services may be construed to supersede any local requirements.

Ch. Trans. 301 can be found at http://www.dot.wisconsin.gov/statepatrol/index.htm.

NEW MEDICAID APPLICANTS AND REINSTATEMENTS AFTER ONE YEAR LAPSE

Carefully read the application memorandum. If the application is not received within 30 days from the date on the memorandum, the date that Wisconsin Medicaid receives the correctly completed application will be the effective date. The effective date cannot be earlier than the date the SMV provider meets all certification requirements, as documented in the Attachment A materials. Applications for reinstatement after a one year lapse in certification are processed like new applications, (except a new provider number is not issued).

Services provided before the assigned certification/reinstatement effective date are not payable. To ensure payment, SMV providers should wait to provide services until the completed SMV application is approved.

Please carefully review the following pages for certification materials and your documents for accuracy. Make a copy of your completed application for your records before mailing it to the Wisconsin Medicaid Program.

ATTACHMENT A

PART 2

SPECIALIZED MEDICAL VEHICLE (SMV) MEDICAID CERTIFICATION MATERIALS

The items below must be accurately completed and sent to Wisconsin Medicaid (unless stated not to send).

A. VEHICLE INFORMATION

1) ___ SMV Information Chart. Fill out **completely,** including sections below the listed vehicles. Medicaid rules in Wis. Adm. Code 105.39 require that each vehicle be equipped with a ramp or lift. Trans 301 rules do not require a ramp or lift to be approved as a Human Service Vehicle (HSV). To be Medicaid certified, all vehicles used for SMV trips must be listed on the chart and must be equipped with a ramp or lift.

2) ___ Attach one of the blue (original carbonless copy) pages from your current Wisconsin Department of Transportation (DOT) Motor Bus/HSV Inspection Report (DOT form SP 4162) for **each** vehicle listed on the Vehicle Chart. The District Inspectors should give both carbonless copies of this 3-ply form to the SMV provider, (per DOT Headquarters). Send either of these 2 blue pages (not a photo copy). HSV inspections must be done annually. The HSV approval dates on all vehicles must be less than 12 months before Wisconsin Medicaid receives all inspection forms **and** the effective date of certification or reinstatement. Each vehicle must be inspected and approved as an HSV by DOT. A copy of this DOT form is attached (for an example only).

- To obtain an HSV appointment for your vehicles, contact your state patrol district office. A Wisconsin Division of State Patrol District map is enclosed for your information. It shows the counties in each district, the contact names and phone numbers.

3) ___ Attach proof of current Vehicle Insurance. (See the separate colored checklist for required insurance documentation **and give a copy to your agent.**) Each vehicle identification number (VIN) on the Vehicle Chart **must** exactly match the VIN(s) on the HSV forms and insurance policy and binder, (if binder sent initially for temporary certification). If the VINs are not included because the policy is for "blanket coverage," the letter from the insurance company must explain your insurance covers all vehicles and the VINs are not listed in the policy. When Wisconsin Medicaid is notified of a policy lapse, the SMV certification will be canceled.

4) ___ Indicate on the Vehicle Chart if you will use the attached Weekly Driver's Vehicle Inspection Report. If you answer no, you must send a copy of recordkeeping procedures for weekly vehicle inspections as required in HFS 105.39. All other inspection report forms, equivalent paper or computer format, submitted must contain every item listed under HFS 105.39, Wis. Adm. Code, and will be subject to review and approval. This could cause a delay in processing. This form, or equivalent, must be completed weekly on each vehicle for recordkeeping and retained for 12 months to be available for an audit. DO **NOT** send actual completed weekly inspection reports to our fiscal agent.

B. DRIVER INFORMATION

1) ___ SMV Driver Information Chart. Fill out **completely,** including section below the listed drivers.

2) ___ Attach copies of current Basic Red Cross first aid cards (or equivalent) for each driver. The date of training **must be within 36 months** of when the correctly completed Driver Chart is received **and** the effective date of certification or recertification.

Attach copies of current cardiopulmonary resuscitation (CPR) cards for each driver. Proof of CPR certification must be shown when the correctly completed Driver Chart is received and the effective date of certification or recertification.

- A copy of a driver's current license as an emergency medical technician, registered nurse, licensed practical nurse or physician assistant will be accepted in place of a first aid and/or CPR card. However, dated evidence of continuing education which includes first aid within past 36 months and current CPR certification must be attached to the license copy.
- If any first aid or CPR card does not include the training date, a signed letter from the instructor, or their agency, verifying the training date(s) **must** be attached.

C. COMPANY INFORMATION

1) ___ Notarized Affidavit (must be notarized to be valid).

2) ___ Certificate of Worker's Compensation Insurance. This is necessary when an SMV company:

- Employs 3 or more employees; or
- Has less than 3 employees but pays more than $500 in payroll within a calendar quarter.

3) ___ Federal regulations stipulate that a provider may not be assigned more than one provider number for the same services at one location. Thus, if the physical address, office location where required SMV records (i.e., weekly vehicle inspection reports, recipients' disability certifications) are kept, is the same as another SMV provider, a written statement of explanation is required. It **must** include: Why separate SMV providers operate at the same address; the officers of each; a statement attesting that each operates completely; separate; and that the payee name and IRS number is not/will not be the same.

FUTURE CHANGES IN YOUR SMV COMPANY

You **must** report changes in provider status, such as, ownership (requires new application), provider name or vehicles **before the change occurs.** Changes must be sent in writing to Wisconsin Medicaid, Attn: Provider Maintenance. These changes include:

- For all vehicles that are added to transport Medicaid recipients, you **must** submit an updated Vehicle Chart, HSV approval forms **and** attach new insurance documentation with VIN(s), that exactly match the Vehicle Chart and HSV forms, **unless policy is for "Blanket Coverage" before** the vehicles are used or no later than 14 calendar days of the first day of service. Wisconsin Medicaid will send notice of approval for the added vehicle(s) and effective date(s).
- Any changes in insurance other than annual renewals - (if changing insurers or obtaining a new replacement policy, the complete insurance documentation on the insurance checklist must be submitted).
- Changes in drivers, their current first aid and CPR cards and documentation of seizure training and training in the use of all ramps, lift equipment and restraint devices of all your vehicles must be maintained in your files.
- For a change of ownership, the new owner must apply as a new SMV provider to obtain a "replacement" provider number to submit claims for dates of service on and after the change of ownership date. The seller's provider number will be canceled effective 1 day before the ownership change date, which will allow payment of claims for dates of service before the change in ownership date.

PROVISIONAL CERTIFICATION

NOTE: All new SMV providers certified or reinstated after a 1 year lapse and providers who have had a change of ownership will be approved for provisional certification for a maximum of 6 months. Medicaid staff will schedule an audit before the certification expires. If the audit cannot be completed before the 6 months expire, the provisional certification will be extended monthly until the audit is complete. No electronic billing will be approved before the audit is conducted and completed and the provider approval granted to bill electronically. The provisional certification and audit applies to the new owner(s) from a change of ownership. Provisional varies from temporary certification, (which is approved for any SMV provider when an insurance binder is sent as documentation before the actual policy is received).

Wisconsin Medicaid
Specialized Medical Vehicle (SMV) Providers
Insurance Documentation Requirements

Certification Requirements

As part of the Wisconsin Medicaid certification application, each new SMV provider must submit the insurance documentation detailed in the checklist on the reverse side of this page. Currently certified SMV providers must submit the same insurance documentation immediately when they change their insurance carriers or obtain a new replacement policy (excluding renewals for the same policy). Providers must send each of the following to Wisconsin Medicaid (at the address in Section A of the checklist), for approval along with the checklist:

- Copy of the current vehicle(s) commercial insurance policy
- Completed current Vehicle Chart(s)
- Letter documenting receipt of payment
- Certification of Insurance

It is the provider's responsibility, not the insurance agency, to ensure that Wisconsin Medicaid receives the complete insurance documentation when it is due. Give your insurance representative a copy of the checklist so he/she knows the specific requirements. To avoid delays in approval by Wisconsin Medicaid, check the insurance documentation for accuracy *before* sending it to the Wisconsin Medicaid Program.

Temporary Certification Requirements

Wisconsin Medicaid will grant temporary certification to SMV providers who submit an insurance binder which documents all of the information required in Section A of the checklist on the reverse side of this page. Temporary certification is granted to new providers or to currently certified providers who change their insurance carrier/agency or obtain a new replacement policy. Temporary certification is limited to a maximum of 60 days from the effective date on the binder or the specified binder expiration date, whichever comes first. Wisconsin Medicaid determines the length of a new or reinstated provider's temporary certification by the initial certification or reinstatement effective date. [Example: The initial certification or reinstatement date assigned is May 15 and the insurance binder is valid May 1 to June 30. Wisconsin Medicaid approves the temporary certification from May 15 to June 30 or 46 days.]

SMV providers must send a copy of their final **Policy, Letter of Receipt, or Certification of Insurance**, which documents all of the information in Section A of the checklist on the reverse side, to be received by Wisconsin Medicaid before the temporary certification ends or Wisconsin Medicaid cancels the provider number. The provider number remains canceled until Wisconsin Medicaid receives the documentation; this causes a lapse in certification. The date that Wisconsin Medicaid receives the acceptable insurance documentation is assigned as the SMV provider's certification reinstatement date. Wisconsin Medicaid will not pay claims with dates of service during the period of lapsed certification. SMV providers must ensure that Wisconsin Medicaid receives a copy of the actual acceptable policy before their temporary certification expires to avoid a lapse in certification.

Changes in Coverage

Wisconsin Medicaid prohibits SMV providers from transporting Medicaid recipients in any vehicle not covered under the terms of the commercial insurance policy on file with Wisconsin Medicaid. Substitution of vehicles is not allowed. Before using any vehicle that is not on file with Wisconsin Medicaid, send the following to Wisconsin Medicaid for approval:

- A copy of the amended insurance policy or change endorsement with the vehicle identification number of each additional vehicle,
- An updated Vehicle Chart(s)

NOTE: Providers may transport recipients as soon as the vehicle is insured and inspected as required under ch. HFS 105.39, Wis. Admin. However, Wisconsin Medicaid must receive the Inspection and Insurance Verification documentation within 14 calendar days of the first date of service.

When Wisconsin Medicaid receives a cancellation notice from an SMV provider's insurance carrier/agency, Wisconsin Medicaid sends a sanction notice to the provider. It states that their provider number will be canceled in 20 days if Wisconsin Medicaid does not receive notice of reinstatement without a lapse from the same carrier/agency (for the same policy), or complete documentation of insurance from the provider. The provider number remains canceled until Wisconsin Medicaid receives the documentation; this causes a lapse in certification. The date that Wisconsin Medicaid receives the acceptable insurance documentation is assigned as the SMV provider's certification reinstatement date. Wisconsin Medicaid will not pay claims with dates of service during the period of lapsed certification.

SMV Insurance Documentation Checklist

Please carefully read the insurance documentation requirements on the reverse side of this page. All new and reinstated SMV providers **must** send the complete insurance documentation detailed below. Currently certified SMV providers who change their insurance carrier/agency or obtain a new replacement policy **must** send it immediately. Attach it to a current Vehicle Chart(s) and send to Wisconsin Medicaid. **All** of the policy items in Section A **must be** contained in your policy, the binder if submitted first, and on all policy renewals. **Do not send** copies of renewal policies; these should be kept in the provider's records. **All** of the items in Section B **must be** included in the letter received from the insurance company, which needs to be signed and dated.

Section A -- Copy of SMV Vehicle(s) Current Commercial Insurance Policy Must Contain:

____ Insurance Company Name

____ Amount of Personal Liability for Each Person (minimum $250,000) and Total Personal Liability for Each Occurrence (minimum $500,000).

OR

____ Amount of Property Damage Insurance on Each SMV Vehicle (minimum $10,000). Exception: A Combined Single Limit (CSL) policy with a minimum of $500,000 will be accepted. The separate $10,000 property requirement will be administratively waived, without a waiver request, only for CSL policies with a minimum liability of $500,000.

____ Insured -- This **must be** a commercial policy, **not** a personal policy, **in the SMV business** (the name on the policy **must** exactly match the SMV name on all Medicaid documents and/or the Medicaid file).

____ All Vehicles used for Medicaid transports **must** be listed on the current Vehicle Information Chart(s) **and the** (binder, too, if submitted first). Vehicle Identification Numbers (VINs) on the binder and policy must *exactly* match VINs on the current Vehicle Chart(s). If the policy is for "blanket coverage" where VINs are not listed, this must be explained in the letter of receipt. Attach a completed current Vehicle Chart.

____ Effective Dates of Current Period of Coverage.

____ Additional Insured **or** Notification Endorsement **is required**. *This is required so the insurer guarantees to notify the Medicaid Program prior to a policy cancellation.* The following **must** be included **in** the policy, the binder if submitted first, and on all policy renewals:

Wisconsin Medicaid
Attn: Provider Maintenance
6406 Bridge Road
MADISON WI 53784-0006

Section B -- On letterhead from the Insurance Company or Agent all the following information needs to be provided on Current Vehicle Insurance:

____ Holder (Insured SMV Medicaid Provider) Name and Policy Number.

____ Effective Dates of Current Period of Coverage.

____ Payment Structure -- How are payments made, (i.e., monthly, quarterly, semi-annually, annually) and is policy paid up-to-date.

____ Signature and Date of Insurance Representative (no initials or signature stamps allowed).

PR11144.KW/PRPERM 5/98
Revised: December 2001

Specialized Medical Vehicle (SMV) Information Chart

SMV Company Name: _____ **City:**_____ **Medicaid Provider #** _____

(New Applicants Skip)

Please Type or Print Distinctly

1. Make a copy of this form **before** completing for use to report any future changes.
2. Retain a copy of your completed form for your files.
3. Send an updated vehicle chart to EDS Provider Maintenance **prior** to any change in vehicles. Attach and send new insurance documentation **before** using additional vehicles.
4. Send **correct and complete** insurance documentation to EDS Provider Maintenance **immediately** when changing your insurance carrier or policy **and** attach a new chart.

Vehicle Identification Number (VIN)	WI License Plate Number Registration AND Expiration Date Month/Year	Year	Make (Manufacturer)	Model	Passenger Capacity With All Secured by Restraints	Wheel-Chair Ramp? Yes/No	Wheel-Chair Lift? Yes/No	Cot or Stretcher? Yes/No
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								

Attach a copy of your current (approval must be within past 12 months) WI Department of Transportation (DOT) Motor Bus/Human Service Vehicle Inspection Report (DOT form SP 4162) for **each** vehicle.

There **must** be passenger restraint devices for *all* passengers. **Does each vehicle have wheelchair, cot or stretcher restraints which secure both the passenger and the wheelchair, cot or stretcher at all times? YES ___ NO ___.**

SMVs must **not** use any vehicle not insured by their own SMV policy; **borrowing vehicles is not allowed. All** vehicles **must** have a wheelchair ramp or lift.

Document Recordkeeping Procedures for Vehicle Inspections. All vehicles *must* be inspected *at least every 7 days* **and** documented (HFS 105.39, Wis. Adm. Code). SMVs are strongly encouraged to use the Weekly Driver's Vehicle Inspection Report provided in the SMV certification application. **Will you use this form? YES ___ NO ___.** If no, attach a copy of the form you will use. All other forms must contain **every** item listed in HFS 105.39, Wis. Adm. Code, and must be reviewed and approved. This may cause a delay in processing.

Vehicle(s) inspections will be performed by (print name):_____ (if more than 1 person, list by printing additional names), _____, _____, and _____, **every** _____ **(fill in day of week).**

_____ _____/_____/_____

Authorized Name **Title** **Signature** **Date**

PR11144.KW/PRPERM 5/98
Revised: December 2001

Specialized Medical Vehicle (SMV) Driver Information Chart

SMV Company Name:_____ **City:**_____ **Medicaid Provider #** _____

(New Applicants Skip)

Please Type or Print Distinctly

An updated chart, or equivalent paper or computer format, reflecting any change in drivers must be maintained in your files. The current first aid and cardiopulmonary resuscitation (CPR) cards and evidence of seizure training and training in the use of all ramps, lift equipment, and restraint devices of all your vehicles for each new driver must also be in your files.

For Each Driver First Name, M.I., Last Name As Appears on License	Wisconsin (or Border State) Driver's License Number and Expiration Date	Regular or Commercial? R/C	List All License Restrictions and Violations	Date of Birth	First Aid Course Name and Date	CPR Course Date	Date of Seizures Training	Date Trained to Use Ramps, Lifts, and Restraints
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								

Attach:

* 1) Copy of **current** first aid card proving completion of Basic Red Cross first aid course, or equivalent, for *each* driver. Date of training **must be within 36 months** of when this correctly completed form is received *and* the effective date of certification or recertification. Also accepted: copy of certain health care licenses, (EMT, RN, LPN, PA) *and* dated proof of *recent* continuing education including first aid.

* 2) Copy of **current** CPR card for each driver. CPR certification must be current when this correctly completed form is received *and* on the effective date of certification or recertification. Also accepted: copy of certain health care licenses, (EMT, RN, LPN, PA) *and* dated proof of *recent* continuing education including CPR.

* If either card does not include the training date, you must attach a signed letter from the instructor, or his/her agency, verifying the training date(s)

.

_____ _____/_____/_____

Authorized Name **Title** **Signature** **Date**

WISCONSIN MEDICAID PROGRAM

SPECIALIZED MEDICAL VEHICLE (SMV) PROVIDERS

AFFIDAVIT

SMV PROVIDER NAME: _____
(must exactly match name on all SMV certification documents)

BUSINESS NAME: _____
(checks payable to, include Inc, Corp; IRS name for IRS # used)

ADDRESS: _____
Street (P.O. Box only not allowed)

_____
City State Zip

TELEPHONE NUMBER(S): _____

TYPE OF OWNERSHIP OF SMV BUSINESS (required to check one):

- ☐ **A Sole Proprietorship**
- ☐ **A Partnership ****
- ☐ **Other**
- ☐ **A Non-profit Association or Corporation ****
- ☐ **A Proprietary Corporation ****

**** List all owners, partners, and officers and the title of each (required):**

print name	**title**	**print name**	**title**
print name	**title**	**print name**	**title**

I, (print name) _____, certify that I am the (print title, i.e. president) _____, of this SMV provider. As the authorized representative, I certify that I fully understand the contents of this affidavit and that the information provided on all certification documents is accurate. I attest that this SMV provider meets all of the certification requirements under HFS 105.39, Wis. Adm. Code, as follows and will meet all requirements as are now in effect or as may later be amended, on a continuous and on-going basis. (Must be notarized, see page 4 of 4.)

SIGNATURE: _____ **DATE:** _____

HFS 105.39, Wis. Adm. Code (effective December 1, 1994):

(1) For MA certification, a specialized medical vehicle provider shall meet the requirements of this section and shall sign the affidavit required under sub. (6) stipulating that the provider is in compliance with the requirements of this section as well as with the requirements of the department of transportation for human service vehicles under ss. 110.05 and 340.01(23)(g), Stats., and ch. Trans. 301, and shall provide proof of compliance when requested by the department.

(2) VEHICLES. (a) Insurance of not less than $250,000 personal liability for each person, not less than $500,000 personal liability for each occurrence and not less than $10,000 property damage shall be carried on each specialized medical vehicle used to transport a recipient.

(b) Each vehicle shall be inspected and the inspection documented at least every 7 days, by an assigned driver or mechanic, to ensure:

1. The proper functioning of the vehicle systems including but not limited to all headlights, emergency flasher lights, turn signal lights, tail lights, brake lights, clearance lights, internal lights, windshield wipers, brakes, front suspension and steering mechanisms, shock absorbers, heater and defroster systems, structural integrity of passenger compartment, air conditioning system, wheelchair locking systems, doors, lifts and ramps, moveable windows and passenger and driver restraint systems;

2. That all brakes, front suspension and steering mechanisms and shock absorbers are functioning correctly;

3. That all tires are properly inflated according to vehicle or tire manufacturers' recommendations and that all tires possess a minimum of 1/8-inch of tread at the point of greatest wear; and

4. That windshields and mirrors are free from cracks or breaks.

(c) The driver inspecting the vehicle shall document all vehicle inspections in writing, noting any deficiencies.

(d) All deficiencies shall be corrected before any recipient is transported in the vehicle. Corrections shall be documented by the driver. Documentation shall be retained for not less than 12 months, except as authorized in writing by the department.

(e) Windows, windshield and mirrors shall be maintained in a clean condition with no obstruction to vision.

(f) Smoking is not permitted in the vehicle.

(g) Police, sheriff's department and ambulance emergency telephone numbers shall be posted on the dash of the vehicle in an easily readable manner. If the vehicle is not equipped with a working two-way radio, sufficient money in suitable denominations shall be carried to enable not less than 3 local telephone calls to be made from a pay telephone. **[NOTE:** Ch. Trans 301.14, requires every HSV to be equipped with some type of 2-way communication system. The system shall be of such design and installation that the vehicle operator shall at all times be able to communicate with either the base of operations or another intermediary party that could communicate with the base of operations.**]**

(h) A provider shall maintain a list showing for each vehicle its registration number, identification number, license number, manufacturer, model, year, passenger capacity, insurance policy number, insurer, types of restraint systems for wheelchairs and whether it is fitted with a wheelchair lift or with a ramp. Attached to the list shall be evidence of compliance with ch. Trans. 301.

(3) VEHICLE EQUIPMENT. (a) The vehicle shall be equipped at all times with a flashlight in working condition, a first aid kit and a fire extinguisher. The fire extinguisher shall be periodically serviced as recommended by the local fire department.

(b) The vehicle shall be equipped with a lift or ramp for loading wheelchairs. The vehicle shall also be equipped with passenger restraint devices for each passenger, including restraint devices for recipients in wheelchairs or on cots or stretchers as defined in s. HFS 107.23(1)(c)4. Both a recipient and the recipient's wheelchair, cot or stretcher shall be secured.

(c) Provision shall be made for secure storage of removable equipment and passenger property in order to prevent projectile injuries to passengers and the driver in the event of an accident.

(4) DRIVERS. (a) Each driver shall possess a valid regular or commercial operator's license which shall be unrestricted, except that the vision restrictions may be waived if the driver's vision is corrected to an acuity of 20/30 or better by the use of corrective lenses. In this event, the driver shall wear corrective lenses while transporting recipients.

(b) 1. Each driver before driving a vehicle or serving as an attendant shall have received all of the following:

a. Basic Red Cross or equivalent training in first aid and cardiopulmonary resuscitation (CPR);

b. Specific instructions on care of passengers in seizure; and

c. Specific instructions in the use of all ramps, lift equipment and restraint devices used by the provider.

2. A driver who was employed before the effective date of this section [December 1, 1994] and who attests in writing that he or she has had prior training in the topics under subd. 1 shall be considered to have fulfilled the requirements under subd. 1.

3. Each driver shall receive refresher training in first aid every 3 years and maintain CPR certification. A driver who is an emergency medical technician licensed under ch. HFS 110, 111 or 112, a licensed practical nurse, a registered nurse or a physician assistant shall be considered to have met this requirement by completion of continuing education which includes first aid and CPR.

(c) The provider shall maintain a current list of all drivers showing the name, license number and any driving violations or license restrictions of each and shall keep that list current.

(5) COMPANY POLICY. Company policies and procedures shall include:

(a) Compliance with state and local laws governing the conduct of businesses, including ch. Trans. 301;

(b) Establishment and implementation of scheduling policies that assure timely pick-up and delivery of passengers going to and returning from medical appointments;

(c) Documentation that transportation services for which MA reimbursement is sought are:

1. For medical purposes only;

2. Ordered by the attending provider of medical service; and

3. Provided only to persons who require this transportation because they lack other means of transport, and who are also physically or mentally incapable of using public transportation;

(d) Maintenance of records of services for 5 years, unless otherwise authorized in writing by the department; and

(e) On request of the department, making available for inspection records that document both medical service providers' orders for services and the actual provision of services.

(6) AFFIDAVIT. The provider shall submit to the department a notarized affidavit attesting that the provider meets the requirements listed in this section. The affidavit shall be on a form developed by and available from the department, and shall contain the following:

(a) A statement of the requirements listed in this section;

(b) The date the form is completed by the provider;

(c) The provider's business name, address, telephone number and type of ownership;

(d) The name and signature of the provider or a person authorized to act on behalf of the provider; and

(e) A "notarization."

(7) DENIAL OF RECERTIFICATION. If a provider violates provisions of this chapter, s. HFS 106.06, s. HFS 107.23 or any other instruction in MA program manuals, handbooks, updates or letters on provision of SMV services 3 times in a 36-month period, the department may deny that provider's request for recertification.

"The Wisconsin Medicaid program requires information to enable the Medicaid program to certify providers and to authorize pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to the Medicaid program administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for those services."

(Notary signature and seal REQUIRED)

Subscribed and sworn to before me this _____ day of _____

_____ in _____ County, WI or _____
NOTARY PUBLIC

My commission expires on _____

Weekly Driver's Vehicle Inspection Report

☒ INSPECTED – OK ∀ NEEDS REPAIR ODOMETER READING_____

VEHICLE LICENSE PLATE #_____

ITEM	BEFORE RUN	DURING RUN	REMARKS
*Doors			
Wheels, Nuts			
*Tires: Properly inflated			
* Minimum 1/8 inch tread			
Gas Cap			
Engine			
Starter			
Alternator Gauge			
Transmission			
Clutch			
Oil Pressure			
Gas Gauge			
*Lights: Head			
* Tail			
* Warning/Emergency Flashers			
* Brake Lights			
Stop Arm			
* Directionals/Turn Signals			
Hazard			
* Clearance			
* Interior/Internal			
Exhaust			
Mirrors			
*Brakes			
Steering – Horn			
*Wipers – Washers			
*Heater – Defrost			
*Front Suspension			
*Steering Mechanisms			
*Shock Absorbers			
*Windows, Windshield & Mirrors: Clean/clear vision			
* No cracks or breaks			

(CONTINUED ON BACK)

Weekly Driver's Vehicle Inspection Report

ITEM	BEFORE RUN	DURING RUN	REMARKS
*Restraint Systems: Driver			
* Passenger			
* Wheelchair Locking Systems (both wheelchair & passenger secured)			
* Cot/Stretcher (both cot or stretcher and passenger secured)			
Jack and Lug Wrench			
Speedometer			
Steps/Floors/Seats			
*Fire Extinguisher			
Reflectors or Flares			
*Working Flashlight			
*First Aid Kit			
Accident Package			
Radio KUT913			
*Lift/Ramp			
*No Smoking Sign Present			
*Emergency Phone Numbers Posted Clearly on Dash			
*Structural Integrity of Passenger Compartment			
*Air Conditioning System			

* Required under HFS 105.39, Wisconsin Administrative Code.

REMARKS

I have inspected all items on this report and found them as noted:

Driver/Mechanic's Name _____ Driver/Mechanic's Signature _____ Date _____

Defects corrected on: _____ Date _____ By: _____

Reinspected by Driver or Fleet Supervisor: _____ Name _____ Signature _____ Date

Specialized Medical Vehicle Company Name: _____ Medicaid Provider #: _____

THIS REPORT, OR EQUIVALENT (PAPER OR COMPUTER), MUST BE DONE EVERY 7 DAYS WHEN THE REQUIRED INSPECTIONS FOR EVERY VEHICLE ARE COMPLETED AND MUST BE RETAINED FOR 12 MONTHS

MOTOR BUS/HUMAN SERVICE VEHICLE INSPECTION REPORT

Wisconsin Dept. of Transportation SP4162 1090 ☐ Annual ☐ Spot Check

MH 57319

Owner EXAMPLE	Location	Time	Fleet #	
Address		Zip	Minors	W/C-HS only
	County Name/Tax Code #	Capacity-Adult		
VIN	Chassis Make & Year	Odometer	Plate # & Year	

NOT O.K.	ITEM	NOT O.K.	ITEM	NOT O.K.	ITEM	NOT O.K.	ITEM
	1 Color		23 Emergency Door		45 Parking Brake		67 Air Cleaner
	2 Gen Body Condition		24 Rear Bumper		46 Instrument Panel		
	3 Headlights/Aim		25 Door Locks-HS only		47 Sunshield		
	4 Not Applicable		26 Not Applicable		48 Low Air/Vacuum Indicator		
	5 Front Clearance Lights		27 Service Door		49 Heater		
	6 Front Turn Signals		28 Steps & Well		50 Defroster		
	7 Hazard Lights		29 Stepwell Light		51 Opening Seals		
	8 Not Applicable		30 Barrier/Guard Rail-HS only		52 Not Applicable		
	9 Outside Mirrors		31 Windshield/Windows		53 First Aid Kit-HS only		
	10 Front Bumper		32 Windshield Wipers		54 Projections		
	11 Not Applicable		33 Windshield Washers		55 Fire Extinguisher		
	12 Not Applicable		34 Seats		56 Emergency Warning Equip		
	13 Rub Rails		35 Aisle Space		57 W/C Fasteners-HS only		
	14 Not Applicable		36 Floor & Mats		58 Lift/Ramp-HS only		
	15 Rear Clearance Lights		37 Seat Belt/Driver		59 Tires		
	16 Rear Turn Signals		38 Cleanliness		60 Rims, Lug Nuts		
	17 Stop Lights		39 Registration Card		61 Battery		
	18 Tail Lights		40 Inside Lettering		62 Power Steering Hoses/Ram		
	19 Rear Reflectors		41 Inside Mirror		63 Vacuum Brake Hoses		
	20 Back-up Lights		42 Horn		64 Water Leak/Radiator		
	21 Not Applicable		43 Steering		65 Belts		
	22 Not Applicable		44 Foot Brake		66 Fuel or Oil Leaks		

Item No.	Remarks/Explanation	Item No.	Remarks/Explanation

☐ **Approved** _____ (Date Inspected)

☐ No Equipment Defects

☐ Minor Equipment Defects
Defect No. — — — — — — — —

X _____ (Mechanic/Owner Signature) (Date Corrected)

X _____ (Inspector Signature) (WSP #)

☐ **Disapproved** OUT OF SERVICE _____ (Date Inspected)

☐ Defect No. — — — — — — — —
Do not operate until vehicle is reinspected and out-of-service sticker is removed by State Patrol.

☐ Defect No. — — — — — — — —
Repairs required. After repairs are completed, vehicle may be operated prior to State Patrol reinspection.

X _____ (Mechanic/Owner Signature) (Date Corrected)

X _____ (Inspector Signature) (WSP #)

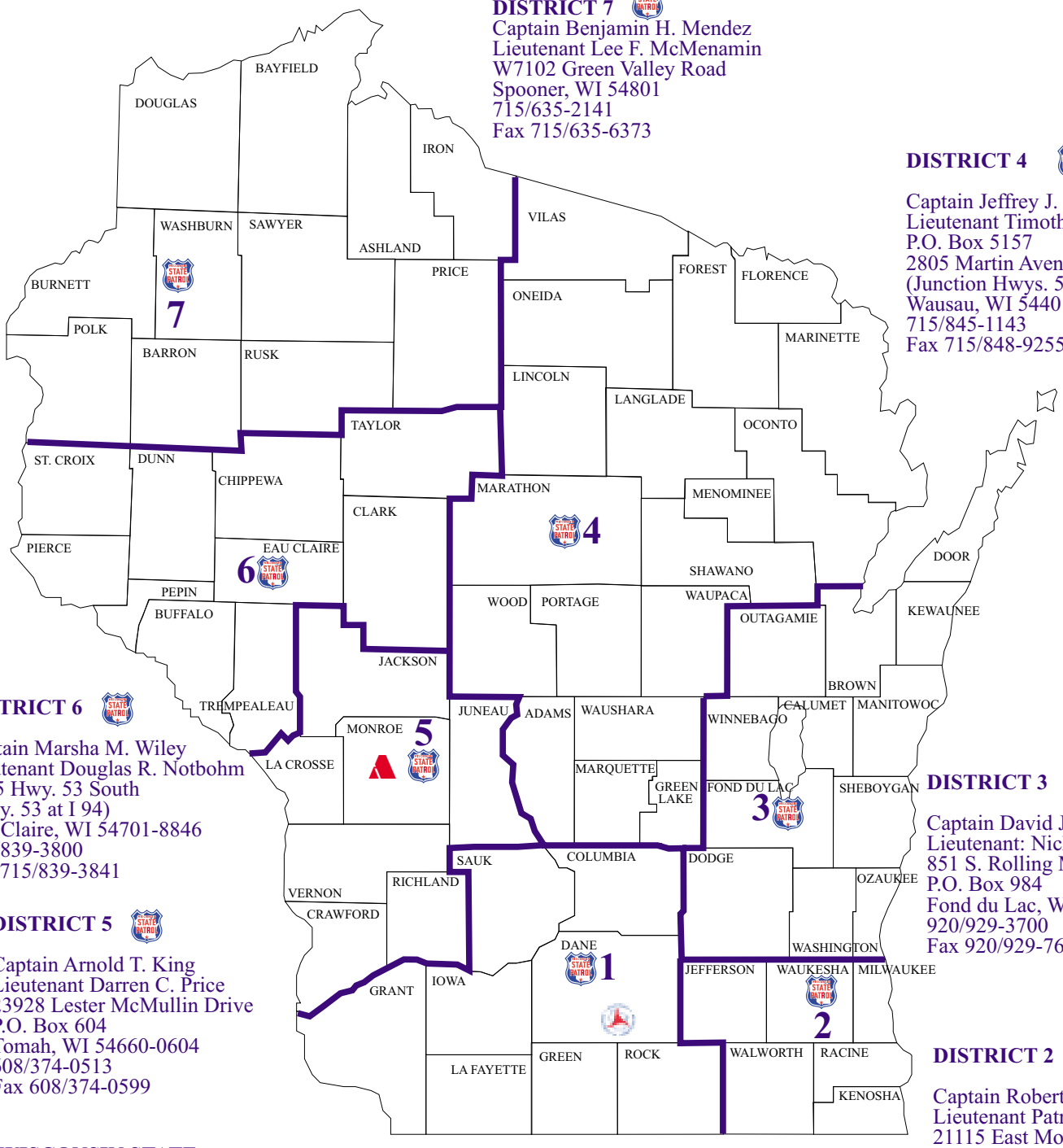
Reinspection Location	Date	Time

☐ **Reinspection Approved** _____ (Date Reinspected)

X _____ (Inspector Signature) (WSP #)

1 - STATE HEADQUARTERS

WISCONSIN
DIVISION OF STATE PATROL
DISTRICT MAP



DISTRICT 7
Captain Benjamin H. Mendez
Lieutenant Lee F. McMenamin
W7102 Green Valley Road
Spooner, WI 54801
715/635-2141
Fax 715/635-6373

DISTRICT 4

Captain Jeffrey J. Frenette
Lieutenant Timothy L. Carnahan
P.O. Box 5157
2805 Martin Avenue
(Junction Hwys. 51 & NN)
Wausau, WI 54401-7172
715/845-1143
Fax 715/848-9255

DISTRICT 6

Captain Marsha M. Wiley
Lieutenant Douglas R. Notbohm
5005 Hwy. 53 South
(Hwy. 53 at I 94)
Eau Claire, WI 54701-8846
715/839-3800
Fax 715/839-3841

DISTRICT 3

Captain David J. Pichette
Lieutenant: Nick Scorcio
851 S. Rolling Meadows Drive
P.O. Box 984
Fond du Lac, WI 54936-0984
920/929-3700
Fax 920/929-7666

DISTRICT 5

Captain Arnold T. King
Lieutenant Darren C. Price
23928 Lester McMullin Drive
P.O. Box 604
Tomah, WI 54660-0604
608/374-0513
Fax 608/374-0599

DISTRICT 2

Captain Robert A. Bereiter
Lieutenant Patricia M. Hansen
21115 East Moreland Blvd.
Waukesha, WI 53186-2985
262/785-4700
Fax 262/785-4723

WISCONSIN STATE PATROL ACADEMY

Major Gerald J. Zuhlsdorf
Lieutenant Roxann L. King
95 South 10th Avenue
Ft. McCoy, WI 54656
608/269-2500
Fax 608/269-5681

DIVISION HEADQUARTERS

Superintendent Douglas L. VanBuren
Colonel Robert B. Young
4802 Sheboygan Avenue
P.O. Box 7912
Hill Farms State Trans. Bldg., Rm. 551
Madison, WI 53707-7912
608/266-3212
Fax 608/267-4495

DISTRICT 1

Captain David C. Heinle
Lieutenant Varla J. Bishop
911 W. North Street
P.O. Box 610
DeForest, WI 53532-0610
608/846-8500
Fax 608/846-8536 (Clerical)
Fax 608/846-8523 (Radio)

Revised by JKR - 2/2001

ATTACHMENT 1
Instructions on how to complete the Specialized Medical Vehicle (SMV) Trip Ticket/Medical Care Verification Form

Use the following instructions to complete the SMV trip ticket form.

All elements listed below must be completed except Element 21, which remains optional.

Element 1: Provider Name

Enter name of transportation provider or business.

Element 2: Vehicle

Enter one of the following:

- Vehicle identification number (VIN).
- License plate number.
- Locally assigned number.
- Human service vehicle (HSV) company or fleet number.

Element 3: Date

Enter date of transportation.

Element 4: Driver Name

Enter name of driver.

Element 5: Driver Signature

Signature of driver.

Element 6: Recipient Name

Enter recipient's complete name.

Element 7: Recipient Identification Number

Enter the number taken from the Wisconsin Medicaid Forward card or a temporary Medicaid ID card that has been provided. Provider should verify that the recipient is eligible for Medicaid at the time the transportation is provided.

Element 8: Unloaded Mileage - Dispatch Location

Enter the exact physical street address, including city and state, where the vehicle is at the time it is dispatched. Be specific in terms of address and street, highway number with mile marker, etc.

Element 9: Unloaded Mileage - Odometer Readings

Enter the beginning and ending unloaded mileage readings. Providers must use actual odometer readings, including tenths of a mile. No other mileage calculations, such as grid maps, city block calculations, etc., will be accepted.

Element 10: Pick Up Address

Enter the exact physical street address, including city and state, where the recipient is picked up.

Element 11: Odometer Reading Start and Time

Enter the exact odometer reading (including tenths of a mile) at the exact location where the recipient is picked up and the time (for example, 10:25 a.m.) the recipient is picked up. Providers must use actual odometer readings. No other mileage calculations, such as grid maps, city block calculations, etc., will be accepted.

Element 12: Drop Off Address

Enter the exact physical street address, including city and state, where the recipient is dropped off.

Element 13: Odometer Reading End and Time

Enter the exact odometer reading (including tenths of a mile) at the exact location where the recipient is dropped off and the time (for example, 10:25 a.m.) the recipient is dropped off. Providers must use actual odometer readings. No other mileage calculations, such as grid maps, city block calculations, etc., will be accepted.

Element 14: Name of Facility

Enter the name of the clinic, hospital, rehabilitation center, etc., where the recipient is taken.

Element 15: Type of Facility or Reason for Trip

Enter the type of facility (e.g., clinic, dental office, physician, etc.) or reason for appointment (e.g., dental appointment).

Element 16: Waiting Time

Enter the exact waiting time (for example, from 10:25 to 11:15 a.m.) if the driver waits for the recipient.

Element 17: Second Attendant's Name

Enter the name of the person who is the second attendant if applicable.

Element 18: Multiple Riders This Trip

Circle "yes" or "no" depending on whether or not there are multiple riders.

Element 19: Name of Primary Rider

Enter the name of the primary rider if applicable.

Element 20: Wheelchair? Cot or Stretcher?

Circle the appropriate response regarding transportation provided.

Element 21: Signature of Person Verifying the Medicaid-Covered Service/Title/Date (optional)

This box must be signed and dated by the person verifying that the recipient is receiving a Medicaid-covered service at that location. This person should also list his or her working title (e.g., receptionist, nurse, doctor, etc.).

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1150 (10/00)

STATE OF WISCONSIN

SPECIALIZED MEDICAL VEHICLE (SMV) TRIP TICKET/MEDICAL CARE VERIFICATION FORM

1. Provider Name _____ 2. Vehicle _____ 3. Date _____

4. Driver's Name _____ 5. Driver's Signature _____

6. Recipient Name	7. Recipient Identification Number
8. Unloaded Mileage - Dispatch Location	9. Unloaded Mileage - Odometer Readings Start End
10. Pick Up Address	11. Odometer Reading Start Time AM/PM
12. Drop Off Address	13. Odometer Reading End Time AM/PM
14. Name of Facility	15. Type of Facility or Reason for Trip
16. Waiting Time AM/PM to AM/PM	17. Second Attendant's Name
18. Multiple Riders this Trip Yes No	19. Name of Primary Rider
20. Wheelchair? Yes No	Cot or Strecher? Yes No
21. Signature of Person Verifying the Medicaid-Covered Service	Title Date

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1150 (10/00)

STATE OF WISCONSIN

SPECIALIZED MEDICAL VEHICLE (SMV) TRIP TICKET/MEDICAL CARE VERIFICATION FORM

1. Provider Name _____ 2. Vehicle _____ 3. Date _____

4. Driver's Name _____ 5. Driver's Signature _____

6. Recipient Name	7. Recipient Identification Number
8. Unloaded Mileage - Dispatch Location	9. Unloaded Mileage - Odometer Readings Start End
10. Pick Up Address	11. Odometer Reading Start Time AM/PM
12. Drop Off Address	13. Odometer Reading End Time AM/PM
14. Name of Facility	15. Type of Facility or Reason for Trip
16. Waiting Time AM/PM to AM/PM	17. Second Attendant's Name
18. Multiple Riders this Trip Yes No	19. Name of Primary Rider
20. Wheelchair? Yes No	Cot or Strecher? Yes No
21. Signature of Person Verifying the Medicaid-Covered Service	Title Date

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT

(For Specialized Medical Vehicle (SMV) Providers)

The State of Wisconsin, Department of Health and Family Services, hereinafter referred to as the Department, hereby enters into an agreement with **(fill in name here)**

Provider Name:

Provider's Name and Number (if assigned). Name must exactly match the name used on all other documents.

a provider of health care services, hereinafter referred to as the Provider, to provide services under Wisconsin's Medicaid Program, subject to the following terms and conditions:

1. The Provider shall comply with all federal laws, including laws relating to Title XIX of the Social Security Act, State laws pertinent to Wisconsin's Medicaid Program, official written policy as transmitted to the Provider in the Wisconsin Medicaid Program Handbooks and all other publications, the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, the Age Discrimination Act of 1975, the Department of Health and Family Services Standards for Equal Opportunity in Service Delivery, section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and the Wisconsin Fair Employment Law, as are now in effect or as may later be amended.

2. The Department shall reimburse the Provider for services and items properly provided under the program in accordance with the "Terms of Reimbursement," as are now in effect or as may later be amended.

3. In accordance with 42 CFR s. 431.107 of the federal Medicaid regulations, the Provider agrees to keep any records necessary to disclose the extent of services provided to recipients, upon request, and to furnish to the Department, the Secretary of the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the provider for furnishing services under the Wisconsin Medicaid Program.

4. The Provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. The Provider shall furnish to the Department in writing:

(a) the names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;

(b) the names and addresses of all persons who have a controlling interest in the provider;

(c) whether any of the persons named in compliance with (a) and (b) above are related to another as spouse, parent, child, or sibling;

(d) the names, addresses, and any significant business transactions between the provider and any subcontractor; and

(e) the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title XIX services programs since the inception of those programs.

5. The Provider hereby affirms that it and each person employed by it for the purpose of providing services holds all licenses or similar entitlements as specified in HFS 101 to 108 and required by federal or state statute, regulation, or rule for the provision of the service.

6. The Provider consents to the use of statistical sampling and extrapolation as the means to determine the amounts owed by the provider to the Wisconsin Medicaid Program as a result of an investigation or audit conducted by the Department, the Department of Justice Medicaid Fraud Control Unit, the federal Department of Health and Human Services, the Federal Bureau of Investigation, or an authorized agent of any of these.

7. Unless earlier terminated as provided in paragraph 8 below, this agreement shall remain in full force and effect for a maximum of one year, with the agreement expiring annually on March 31. Renewal shall be governed by s. HFS 105.02(8), Wisconsin Administrative Code.

8. This agreement may be terminated as follows:

(a) By the provider as provided at s. HFS 106.05, Wisconsin Administrative Code.

(b) By the Department upon grounds set forth at s. HFS 106.06, Wisconsin Administrative Code.

"The Wisconsin Medicaid program requires information to enable the Medicaid program to certify providers and to authorize pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to the Medicaid program administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for those services."

SIGNATURES FOLLOW ON PAGE 3

ALL THREE PAGES OF THIS PROVIDER AGREEMENT MUST BE RETURNED TOGETHER.

Name of Provider (Typed or Printed)

Physical Street Address (list others below*)

City State Zip

TITLE:

BY:
Signature of Provider

DATE:

(For Department Use Only)

STATE OF WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES

BY:

DATE:

* If **all** required SMV records, (i.e., weekly vehicle inspection reports, drivers and vehicles compliance documentation, recipients' disability certifications, trip tickets, etc.) are not kept at the physical street address above, list each additional location where records are kept. Attach a copy of this page as needed to list **all** locations and send updates to Wisconsin Medicaid.

1. Street: City: State: Zip:
2. Street: City: State: Zip:
3. Street: City: State: Zip:

NOTE: All SMV providers who are newly certified or reinstated after a 1 year lapse will be approved for provisional certification for a minimum of 6 months. Medicaid staff will schedule an audit with you before the certification expires. If the audit cannot be completed before the 6 months expire, the provisional certification will be extended monthly until the audit is complete. No electronic billing will be approved before the audit is completed. The provisional certification and audit applies to the new owner(s) from a change of ownership. Provisional varies from temporary certification, (which is approved for any SMV provider when an insurance binder is sent as documentation before the actual policy is received).

MODIFICATIONS TO THIS AGREEMENT CANNOT AND WILL NOT BE AGREED TO. THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE.

Print clearly, this is your mailing label. For recertification (renewals) ONLY. Fill in the address below if the processed Agreement should be sent to a different address than the physical street address identified at the top of this page.

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT

(For Specialized Medical Vehicle (SMV) Providers)

The State of Wisconsin, Department of Health and Family Services, hereinafter referred to as the Department, hereby enters into an agreement with **(fill in name here)**

Provider Name:

Provider's Name and Number (if assigned). Name must exactly match the name used on all other documents.

a provider of health care services, hereinafter referred to as the Provider, to provide services under Wisconsin's Medicaid Program, subject to the following terms and conditions:

1. The Provider shall comply with all federal laws, including laws relating to Title XIX of the Social Security Act, State laws pertinent to Wisconsin's Medicaid Program, official written policy as transmitted to the Provider in the Wisconsin Medicaid Program Handbooks and all other publications, the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, the Age Discrimination Act of 1975, the Department of Health and Family Services Standards for Equal Opportunity in Service Delivery, section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and the Wisconsin Fair Employment Law, as are now in effect or as may later be amended.

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(d) the names, addresses, and any significant business transactions between the provider and any subcontractor; and

(e) the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title XIX services programs since the inception of those programs.

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Physical Street Address (list others below*)

City State Zip

TITLE:

BY:
Signature of Provider

DATE:

(For Department Use Only)

STATE OF WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES

BY:

DATE:

* If **all** required SMV records, (i.e., weekly vehicle inspection reports, drivers and vehicles compliance documentation, recipients' disability certifications, trip tickets, etc.) are not kept at the physical street address above, list each additional location where records are kept. Attach a copy of this page as needed to list **all** locations and send updates to Wisconsin Medicaid.

1. Street: City: State: Zip:
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3. Street: City: State: Zip:

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Print clearly, this is your mailing label. For recertification (renewals) ONLY. Fill in the address below if the processed Agreement should be sent to a different address than the physical street address identified at the top of this page.